STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295044	A. BUILDING _____ B. WING _____	C 02/27/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSTONE OF NORTHERN NEVADA	1950 BARING BLVD SPARKS, NV 89434

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F 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of a complaint investigation initiated on 1/29/08 and finalized on 2/27/08. Complaint #NV00017094 alleged that the facility failed to assess and evaluate a resident for change in condition and failed to resolve a grievance in a timely manner. The complaint was substantiated with federal deficiencies cited. (F166, F309, and F327) The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.	F 000	*This plan of correction is* prepared *and executed because it is required by the provisions of the state and federal regulations and not because* ***Hearthstone of Northern Nevada*** *agrees with the allegations and citations listed on the statement of deficiencies.* ***Hearthstone of Northern Nevada*** *maintains that the alleged deficiencies do not, individually and collectively, jeopardize the health and safety of the residents, nor are they of such character as to limit our capacity to render adequate care as prescribed by regulation. This plan of correction shall operate as* ***Hearthstone of Northern Nevada*** *written credible allegation of compliance.*	
F 166 SS=D	483.10(f)(2) GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to make prompt efforts to resolve grievances made by a residents family member/power of attorney for one resident. (Resident #1) Findings include: Resident #1: The resident was admitted to the facility on 11/30/07 with diagnoses including femur neck fracture, vascular dementia, coronary	F 166	*By submitting this plan of correction,* ***Hearthstone of Northern Nevada*** *does not admit to the accuracy of the deficiencies. This plan of correction is not meant to establish any standard of care, contract, obligation, or position, and* ***Hearthstone of Northern Nevada*** *reserves all rights to raise all possible contentions and defenses in any civil or criminal claim, action or proceeding.*	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Debra M. Lobo RN	DIRECTOR OF NURSING SERVICES	4/11/08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 166	Continued From page 1 atherosclerosis, osteoarthritis, and benign hypertension. On 1/29/08 at 11:15 AM, in interview, Resident #1's son reported that he requested that he be able to speak with the Interim Administrator. He was told by the receptionist that he could not have the phone number to call the Administrator and had been directed to speak to the Director of Nurses (DON). He stated that he had made a complaint to the DON on 12/6/08, related to some concerns he had had about the resident's care, including the lack of elevation of her lower extremities and the failure to apply support stockings as had been ordered by the physician. He then reported that the DON had been "shocked and apologetic, and wrote down all of the information and assured him that his concerns would be addressed and fixed." Later, on the same day, he found Resident #1 out of her bed packing a suitcase without support stockings on. He reported that he then spoke with the Interim Administrator about his concerns on 12/7/07. He reported that at that time the administrator assured him that he took the complaint seriously and that the problems would be resolved. The resident's son reported that he had observed the resident numerous times without her legs elevated and without her support stockings as ordered. He had asked the nursing staff on several occasions to elevate her legs and place the support stockings on the resident's legs. He further reported that he had a private meeting on 12/10/07 with the Interim Administrator where he was again assured that the complaints and concerns would be addressed.	F 166	***F 166 Grievances*** ***The facility failed to make prompt efforts to resolve grievances.*** • ***Resident #1 and Resident #2 have been discharged from the facility.*** • ***All residents residing in the facility have the potential to be affected by this practice.*** • ***The measures that will be put into place are as follows:*** 1. ***The grievance policy will be discussed and reviewed in all-staff.*** 2. ***Grievance Logs will continue to be kept by SSVCS per policy for prompt follow-up.*** • ***Grievances will continue to be monitored in stand-up, on a daily basis and performance improvement committee, on a monthly basis, for resolution*** • ***This corrective action will be in-serviced on 4-8-08 and in place by 4-22-08.***	

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F 166	Continued From page 2	F 166		

The Interim Administrator was interviewed on 1/29/08 at 1:15 PM. He reported that he had written down and referred Resident #1's son's concerns to the DON immediately after his telephone conversation. The DON then reported back to him that the concerns were resolved and that she had followed up to ensure that the appropriate care had been given to Resident #1 on the dates of 12/7/07, 12/8/07, and 12/9/07. He reported that on 12/10/07 Resident #1's son had given him a typed letter of his concerns. The Administrator then told him that if he had any further concerns to contact the DON directly.

On 1/29/08 at 10:55 PM the DON was interviewed. She reported that she could not recall any interaction with Resident #1 or any issues that may have arisen during the stay. She reported that she would look for any documentation of any complaints made by the resident's son. She reported that the Social Worker may have been involved.

On 1/30/08 at 12:50 AM, the Social Worker was interviewed. She stated that she had no knowledge of the grievance. She reported that she "vaguely remembered a hand written note" by the Interim Administrator and that the issues that were raised by the resident's son involved nursing care. She reported that she had never seen the grievance form prior to the interview.

On 1/29/08 at 1:15 PM a grievance form was produced by the DON that was dated as being received on 12/6/08. Upon review, the grievance form was found to be incomplete. The Documentation of Follow-up (Section III), and the Resolution of Grievance/Complaint (Section IV), were blank. Copies of the record were not

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F 166	Continued From page 3 provided on 1/29/08 as requested. On 1/30/08 at 11:15 AM a copy of the grievance form was produced by the DON that had all sections completed. When asked if she had completed the form prior to copying, she reported "yes I filled in some of the information yesterday while you were waiting for copies and I completed it today." The DON then produced a typewritten and signed statement that she had made a "late entry on 1/30/08." Sections III and IV of the document provided to the surveyor on 1/30/08 were found to be complete with a date of 12/10/07. Review of Resident #1's record found no evidence or indication that Resident #1 was non-compliant with the elevation of her legs or tha she had removed the support stockings.	F 166		
F 309 SS=G	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on facility and acute care hospital record review, and staff and resident interview, it was determined that the facility failed to assess and evaluate a change in condition for one resident. (Resident #1) Findings include:	F 309		

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F 309	Continued From page 4 Resident # 1: The resident was admitted to the facility on 11/30/07 with diagnoses including femur neck fracture, vascular dementia, coronary atherosclerosis, osteoarthritis, and benign hypertension. On 1/30/08 at 11:30 AM, an interview was conducted with Resident #1's roommate. The roommate was documented as clear in mentation. She reported that she had called her own son on the telephone and asked him to contact Resident #1's son to come in and check on her because (Resident #1) was in bad shape. She further reported that the nurse taking care of Resident #1 (LPN #2) would not check on the her, although she had asked her to do so several times during the night because she "wasn't sure if (Resident #1) was going to make it." She further reported that she stayed up with (Resident #1) throughout the night of 12/19/07 to watch over her because the nurses would not. Resident #1's roommate reported that she used a walker and walked down the hall and got the nurses to come and check on her, but they just pulled the curtain around (Resident #1) for privacy, and told Resident #1's roommate "never mind." On 1/29/08 at 11:15 AM, in interview, Resident #1's son stated that he came in as a result of the roommate's son contacting him. He reported that when he arrived at the facility, Resident #1 was incoherent, very hot to the touch, and he was told that her oxygen saturation level was 62% (normal range is 90-99%). He reported that he asked LPN #1 to "please send" his mother to the hospital and that he was very concerned about her condition.	F 309	*F 309 Quality of Care* *The facility failed to assess and evaluate a change in condition for one resident.* • *Resident #1 and Resident #2 have been discharged from the facility.* • *All residents residing in the facility have the potential to be affected by this practice.* • *The measures that will be put into place are as follows:* 1. *In-service will be conducted on 4-9-08 with the nursing staff to re-enforce what constitutes a change in condition.* 2. *The change in condition form will be readily available to charge nurses and attached to the 24 hour report.* 3. *Physician, PA, NP, and family will also be promptly notified by the charge nurse of a change in condition on a shift by shift basis.*	

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F 309	Continued From page 5 Review of the facility record revealed no evidence that LPN #2 responded to the roommate's concerns about Resident #1. Numerous attempts were made to contact LPN #2. No interview could be obtained. On 1/31/08 at 12:54 PM, in interview, LPN #1 reported that she had no indication that Resident #1 had had a change in condition until the physical therapist refused to treat the resident due to her change in condition. She reported that the night shift nurse (LPN #2) did not mention any changes with Resident #1 to her. She further reported that the son approached her shortly after the resident returned from physical therapy, and was very upset saying please send my mother to the hospital. LPN #1 reported that she "sent the resident to the hospital because the son (who), was the power of attorney had requested it." Record review further revealed that LPN #1 documented in the "Daily Skilled Nurses Notes" dated 12/20/07 at 8:00 AM: "son at bedside at 8:30 AM and request to send to hospital." Review of the facility record revealed that Resident #1 had been taken to the Physical Therapy Department on 12/20/07 at 8:00 AM for treatment and was found by the physical therapist to be "weak, and unable to follow commands." The therapist "sent" the resident "back" as she was unable to participate in therapy. Record review revealed that the resident was returned to her room and placed in bed. Her oxygen saturation was documented as being 74% (normal range 90-99%). Record review revealed that the "son was at the bedside" at 8:30 AM requesting nursing staff to transfer the resident to the hospital.	F 309	4. *Nurses will be required to complete walking rounds with the on-coming replacement nurse.* 5. *Oxygen saturations are now being monitored for those patients on O2 or prn O2 on a shift by shift basis and documents on the treatment records. Any changes in O2 requirements will be adjusted and MD notified.* 6. *The pain management program continues to be in place with pain scales monitored before and after administration of pain medications and non-pharmaceutical interventions for pain relief.* • *This will be monitored on a daily basis for change in condition by the 24-hour report and discussed in stand-up. Monthly follow-up will be monitored in Standards of Care.* • *This corrective action will be in-serviced on 4-8-08 and in place by 4-22-08.*	

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Record review revealed 911 was called at 8:45 AM. Review of the Regional Emergency Medical Services Authority ambulance report revealed that the call was received at 9:16 AM.

Review of the acute care hospital record revealed that Resident #1 had been seen by a physician at the emergency department on 12/20/07 at 10:20 AM. The resident was documented to be in an "altered mental state." The physician documented on the medical record that the resident had been experiencing an opiate overdose and was given two doses of Narcan (a medication that counteracts opioid drugs). After that, the resident was coherent and able to converse appropriately with family and staff. Further review of the acute care record revealed no further incoherent behavior after the Narcan was administered and the Fentanyl patch was removed and discontinued.

Review of the record revealed that on 12/18/07 at 8:00 PM, Resident #1 had been ordered to have a transdermal patch containing Fentanyl (an opioid analgesic) 50 micrograms. Further review revealed no evidence that Resident #1 had been assessed or evaluated for a change in condition or response to the prescribed opioid (opiate derived narcotics) analgesics. Review of the medication administration record that related to the administration of the Fentanyl patch revealed no evidence that Resident #1 had been assessed or evaluated for a change in condition or response to the medication.

Review of the acute care hospital record revealed that the resident was admitted to the acute facility on 12/20/07 at 9:30 AM. She was diagnosed with

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F 309	Continued From page 7 an opioid overdose, altered mental status, pneumonia, and dehydration. The record revealed that the resident was treated at the acute care facility for five days.	F 309	*F 327 Hydration* ***The facility failed to ensure adequate hydration for one resident.***	
F 327 SS=D	483.25(j) HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to ensure adequate hydration for one resident. (Resident #1) Findings include: Resident #1: The resident was admitted to the facility on 11/30/07 with diagnoses including femur neck fracture, vascular dementia, coronary atherosclerosis, osteoarthritis, and benign hypertension. Review of the record revealed that the resident was transferred to an acute care hospital at 9:30 AM on 12/20/07. Review of the acute care hospital record revealed that the resident was treated at the acute care hospital for five days for opioid overdose, altered mental status, pneumonia, and dehydration. Record review revealed that the resident had abnormal laboratory studies consistent with dehydration including: Blood urea nitrogen: 30 (normal range 7-17)	F 327	***• Resident #1 and Resident #2 have been discharged from the facility.*** ***• All residents residing in the facility have the potential to be affected by this practice.*** ***• The measures that will be put into place are as follows:*** ***1. An assessment for dehydration will be completed and scored on admission. Those residents shown at risk for dehydration will then have care plan interventions implemented.*** ***2. An in-service to all nurses will include requirements related to hydration of residents.*** **** po intake*** **** skin and turgor*** **** vital signs*** **** oral mucosa***	

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F 327	Continued From page 8 Creatinine: 1.1 (normal range 0.7-1.2) Review of the acute care hospital record revealed that the resident had a blood pressure of 82/49, and a pulse of 91 upon admission at the emergency department. Further review revealed that the resident was treated with intravenous fluids to correct the dehydration during her admission to the acute care hosiptal. On 1/30/08 at 1:00 PM the Director of Nurses was interviewed. She reported that she was unaware that the resident had been dehydrated and produced a "care plan" dated 12/07/07 that listed the following "nursing interventions": 4. Assess skin color, temperature, turgor, and oral mucosa. Document findings, and report to Physician as warranted. 5. Encourage fluid intake and adequate nutrition. 7. Monitor intake and output if warranted. Review of the facility documentation revealed no evidence that the above listed interventions had been implemented with the exception of one entry in the nurses notes dated 12/17/07 that read: "Fluids encouraged frequently." The review further revealed no evidence that the resident had ever been assessed for dehydration. Review of "Daily Meal Record" (reported by the DON to be used for recording percentages of meals eaten and amount of fluids consumed), for Resident #1 was found to be incomplete.	F 327	** encouragement of po intake* ** adequate nutritional status* ** placed on I & O if warranted* • *The Change of Condition form will now be filled out by the charge nurse every shift. The physician, PA, NP, and family will be notified. The form will then be placed in the 24-hour report.* • *This will be monitored on a daily basis with Standards of Care review of residents. The hydration aide will be notified of those residents at risk and will offer extended hydration, with documentation of consumption, on a daily basis to the charge nurse.* • *This corrective action will be in-serviced on 4-14-08 and in place by 4-22-08.*	